

Minnesota Senior Health Options (MSHO)

(Summary by Brenda Schmitthenner)

The Minnesota Dept. of Health Services has developed a program called the Minnesota Senior Health Options (MSHO) which combines Medicare and Medicaid financing and acute and LTC service delivery systems. This project facilitates the integration of primary, acute and long term care services for people over 65 who are eligible for both Medicare and Medicaid benefits. Approximately 48,000 seniors receive Medicaid through Minnesota's Medicaid program called Medical Assistance (MA). Around 46,000 seniors are eligible for both Medicare and Medicaid. Around 18,000 of these dually eligible seniors live in the seven county metro area. Minnesota has been granted waivers that allow the state to combine the purchase of both Medicare and Medicaid services into one contract managed by the state. The waivers allow for contracting with smaller HMOs. The federal waivers granted Minnesota a Medicare risk adjustment payment for frail elderly dual eligibles in the community as an incentive to prevent unnecessary institutionalization. This project is being implemented in the seven county metro area and will cover a five year period.

This project is expected to address problems identified in the current system including: fragmented clinical systems, poor clinical incentives, duplicative administration, cost shifting between providers and programs, and a lack of accountability. Each SNF, hospital and home care agency has its own case management. Communication is lacking between the different levels of care providers. The needs of the frail elderly frequently fall through the cracks. There is no coordination of services

between the different levels of care for seniors. Under fee-for-service, Medicare pays doctors more if they treat seniors in the hospital or clinic instead of a SNF. Since those who manage acute care services are not at risk for LTC costs, this payment arrangement sets up an incentive to institutionalize rather than work to prevent unnecessary SNF placements. Providers are forced to duplicate paperwork – send one bill to Medicare and another to Medicaid for the same service. Thus, there is a flurry of confusing and unnecessary paperwork sent to seniors. Hospitals have incentives to admit seniors but not to keep them very long. SNFs are not reimbursed at a higher rate when a senior needs more care, so it is more cost effective for the SNF to send the senior to the hospital. Health plans have no incentive to keep seniors in their own home rather than a SNF. No one can track how much seniors really cost because payments are fragmented between programs and payers.

Medicare policy and reimbursement drive clinical decisions that in turn affect Medicaid utilization and expenditures. Integrated Medicare and Medicaid funding can provide better clinical and cost incentives for seniors who are eligible for both. Integrated Medicare and Medicaid capitations provide the flexibility needed to reduce conflicts between Medicare and Medicaid policy. Integrated financing allows health plans and LTC providers to develop collaborative clinical delivery structures and strategies to improve quality and accountability for services for seniors. Once financial barriers are removed, health plans and providers can coordinate case management. There is no incentive for cost shifting when one entity is responsible for a full range of services.

The goals for this project are: to reorganize the service delivery system to create a seamless point of access for all services for participants and providers, to control overall

cost growth by providing incentives for lowest cost appropriate care, changing utilization patterns and reduce cost shifting, and create a single point of accountability for tracking total costs and outcomes of care.

Since 1985, Minnesota has been enrolling recipients of Medicaid, including seniors, into managed care plans (PMAP). Currently 29,150 of Minnesota's 51,000 seniors who receive Medicaid are enrolled in managed care plans through PMAP. Of these PMAP enrollees, 15,200 live in SNFs and 13,950 live in the community. PMAP has offered a Medicare risk plan also to those seniors that have dual eligibility. Services through PMAP include: Medicare deductibles and co-insurance, physician visits, medical supplies and DMEs, dental, hospitalization, rehab therapies, prescriptions, psychiatric care, medical transportation and some home care services. SNF per diem fees and community based waived services are not paid by PMAP.

Under Minnesota's Senior Health Options (MSHO), participants are entitled to receive all services under Medicaid through PMAP, plus all Medicare A and B services. Health plans also provide extended benefits to frail elderly recipients who are eligible for a SNF. A unique feature of MSHO requires all participating health plans to pay for the first 180 days of care in a SNF for those participants who enrolled in the plan while living in the community. This feature maximizes the opportunity for innovation in non-institutional care and prevention of early institutional placement, especially for those who have chronic care needs.

The state negotiates contracts with HMOs and/or Community Integrated Service Networks (CISNs) for capitated risk-based Medicare and Medicaid services. The state manages these contracts under an agreement with HCFA. All MSHO plans must have a

PMAF contract in each county in which they offer MSHO. A model MSHO contract between the state and MSHO contractors was developed and approved by HCFA.

Health plans participating in MSHO have been encouraged to develop new partnerships with LTC providers. As a result of a new awareness of the need for better coordination between acute and LTC systems, a number of geriatric care networks have been developed in the metro area. These new business ventures vary in structure and risk sharing arrangements. These new entities include: an organization which brings physician services and care coordination by geriatric nurse practitioners directly to SNF residents, a partnership between an HMO, hospitals, clinics, and SNFs, a hospital entity partnered with a broad based LTC provider, a group of LTC providers who have created a joint venture for business arrangements with clinics and hospitals to manage a full spectrum of services on a subcapitated basis, and a group of SNFs have formed a cooperative for more efficient contracting and purchasing arrangements.

People who are over 65 and are eligible for both Medicare and Medicaid benefits are eligible to enroll in a MSHO. MSHO is offered as a voluntary option to the standard PMAF plan. There is a single enrollment process for both Medicare and Medicaid services, and this process is conducted by the county. Health Plans market to the MSHO enrollees. Enrollees may disenroll on a monthly basis. MSHO has served about 5,700 enrollees in its three years of existence. Enrollment began in the first two counties in February 1997.

Each MSHO enrollee has access to a case manager who conducts or arranges appropriate assessments and coordinates the overall continuing care of each enrollee. MSHO plans ensure that the enrollees and family are involved in care planning and

treatment decisions. All MSHO plans are expected to coordinate medical and social service needs with family caregivers as well as with local social agencies and volunteer organizations. Each plan has the flexibility to create a clinical design that fits within their own system.

Several levels of QA have been built into the MSHO project. The Minnesota Dept. of Health is responsible for licensing, oversight and monitoring of all HMOs and CISNs. Minnesota incorporates QA for Medicare services into its PMAP managed QA system and reports periodically to HCFA about plan compliance. Portions of the standard set of HEDIS utilization measures will be collected. Additional outcome measures more specific to elderly chronic care needs have been developed by the MSHO QA subcommittee. A special client satisfaction survey will be implemented as well as a disenrollment survey. The current PMAP compliant and appeals system including access to the state PMAP Ombudsman and county advocates and the fair hearing process is available to all MSHO participants. A formal Advisory Committee comprised of 30 members meets quarterly for updates and input into MSHO.

The state has subcontracted with the National Chronic Care Consortium (NCCC) for assistance in the development of a Technical and Educational Program (TEAP). This program provides expert resources for enabling networks participating in MSHO to integrate acute and LTC services including concepts, clinical expertise and related tools. NCCC is known for its work in developing clinical integration tools such as assessment instruments and protocols, and for compiling information from all over the country on the integration of acute and LTC.

DHS provides each MSHO contractor with a monthly per capita payment per enrollee which includes the PMAP capitation, a Medicaid SNF add-on, and the average elderly wavier payment as appropriate per MSHO policy. HCFA makes direct payment to each MSHO contractor for the monthly-adjusted average per capita costs (AAPCC) capitation. MSHO provides an increased Medicare capitation for frail elderly by applying an AAPCC risk adjustment factor. In exchange for these two Medicaid and Medicare capitation payments, MSHO contractors must provide all medically necessary Medicaid, Medicare, Elderly Wavier and SNF services for the individuals enrolled in the plan except for SNF per diem costs.

FOR MORE INFORMATION: www.dhs.state.mn.us/agingint/services/mhosumm.htm